

July 31, 2003

Re: Medical Dispute Resolution
MDR #: M2-03-1103-01
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ____ for an independent review. ____ has performed an independent review of the medical records to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation.

Clinical History:

This female patient suffers with a history of shoulder dislocation, as well as left arm weakness and diffused left shoulder pain resulting from a work-related injury on _____. She subsequently had physical therapy that allowed her to return to work as of 02/04/03, along with a return to all normal activities. She also had sequential muscle stimulation. Her E.R. x-ray revealed a "slight separation of the shoulder".

Disputed Services:

RS4i sequential stimulator.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the equipment in question is not medically necessary in this case.

Rationale:

This therapy is only indicated for acute injury treatment, not chronic treatments. In the reviewer's experience, it also provides temporary relief that is neutralized with the onset of normal activity. It is doubtful that the use of the sequential muscle stimulation unit was responsible for this patient's ability to maintain full normal activities and return to work.

I am the Secretary and General Counsel of ____ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ____ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on May 14, 2003.

Sincerely,